Opening Doors-Connecticut

A Framework to End and Prevent Homelessness in Connecticut

June 2012
What’s happened since January?

BRIEFING FROM COORDINATING COMMITTEE
Reaching Home Systems Performance

BASELINE DATA ON HOMELESSNESS

JUNE 2012
People Experiencing Homelessness in CT

Point in Time

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Persons</th>
<th>Adults without Children</th>
<th>Persons in Households with Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>4,208</td>
<td>2,903</td>
<td>1,305</td>
</tr>
<tr>
<td>2010</td>
<td>4,338</td>
<td>3,011</td>
<td>1,327</td>
</tr>
<tr>
<td>2011</td>
<td>4,451</td>
<td>3,064</td>
<td>1,387</td>
</tr>
<tr>
<td>2012</td>
<td>4,219</td>
<td>2,915</td>
<td>1,304</td>
</tr>
</tbody>
</table>

Source: CT PIT
Sheltered vs. Unsheltered
CT Point in Time 2012

(unsheltered figures are from 2011 PIT; unsheltered persons were not counted in 2012)

Source: CT PIT
Adults without children experiencing Chronic Homelessness
CT Point in Time 2012

Source: CT PIT
People Using Shelters and Transitional Housing Over the Course of the Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Persons</th>
<th>Adults without Children</th>
<th>Persons in Households with Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>12,892</td>
<td>9,386</td>
<td>3,506</td>
</tr>
<tr>
<td>2011</td>
<td>13,962</td>
<td>9,874</td>
<td>4,088</td>
</tr>
</tbody>
</table>

Source: CT HMIS
Households Using Shelters and Transitional Housing over the Course of the Year

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Households</th>
<th>Households without Children</th>
<th>Households with Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>10,535</td>
<td>9,366</td>
<td>1,169</td>
</tr>
<tr>
<td>2011</td>
<td>11,385</td>
<td>9,850</td>
<td>1,535</td>
</tr>
</tbody>
</table>

Source: CT HMIS
Adults without Children, by Age Group, Using Shelters and Transitional Housing over the Course of the Year

(Approx. 280 people were of unknown age)

Source: CT HMIS
People new to shelter vs. returning to shelter from a prior year (2003 or after)

Source: CT HMIS

FFY 2011
- New to Shelter
- Returned to Shelter

Persons in Households with Children:
- 76% New to Shelter
- 24% Returned to Shelter

Adults with Children:
- 49% New to Shelter
- 51% Returned to Shelter

Source: CT HMIS
TARGETED REDUCTIONS IN HOMELESSNESS AMONG PRIORITY POPULATIONS
JUNE 2012
Goals

• Finish the job of ending chronic homelessness within 5 years

• Prevent and end homelessness among Veterans within 5 years

• Prevent and end homelessness among families, youth and children within 10 years

• Set a path for ending all types of homelessness

Year 1 = 2012
Families with Children (annual)

TARGETED REDUCTIONS IN FAMILY HOMELESSNESS
Families served annually by shelters and transitional housing
Opening Doors Connecticut 2012-2022
2010 and 2011 are actuals from CT HMIS

Data source for tracking: CT HMIS
Families Homeless at Point in Time
Opening Doors Connecticut 2012-2023
2010, 2011, and 2012 are actuals from CT PIT

Data source for tracking: CT PIT
Adults Experiencing Chronic Homelessness

**TARGETED REDUCTIONS IN CHRONIC HOMELESSNESS**
Adults Chronically Homeless at Point in Time
Opening Doors Connecticut 2012-2017

2010, 2011, and 2012 are actuals from CT PIT

Data source for tracking: CT PIT
Veterans

TARGETED REDUCTIONS IN VETERAN HOMELESSNESS
Veterans Homeless at Point in Time
Opening Doors Connecticut 2012-2017
2010, 2011, and 2012 are actuals from CT PIT

Data source for tracking: CT PIT
Changing Strategies to Get to Zero - Families

**2010**
- Shelter/TH only: 89%
- RR: 6%
- SH: 5%

**2021**
- Shelter/TH only: 35%
- Prevention: 13%
- Rapid Re-Housing: 24%
- Supportive Housing: 14%
- Affordable Housing: 14%

Legend:
- Prevention
- Rapid Re-Housing
- Supportive Housing
- Affordable Housing
- Shelter/TH only
### Average Annual Housing Assistance Targets 2012-2016

**Families with Children**

Estimate as of 6/2012 based on current available data; numbers are averages over the 5 year period.

<table>
<thead>
<tr>
<th>Prevention Strategies</th>
<th>105 at-risk Families per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Re-Housing</td>
<td>185 homeless Families per year</td>
</tr>
<tr>
<td>Deeply Affordable Housing</td>
<td>70 homeless Families per year</td>
</tr>
<tr>
<td>New Permanent Supportive Housing</td>
<td>40 homeless and chronically homeless Families per year</td>
</tr>
</tbody>
</table>
Changing Strategies to Get to Zero Chronically Homeless Adults

2011
- Supportive Housing: 23%
- Shelter or Transitional Hsg only: 77%

2016
- Supportive Housing: 98%
- Shelter or TH only: 2%

Supportive Housing

Shelter or TH only
Average Annual Housing Assistance Targets 2012-2016
Chronically Homeless Adults

Estimate as of 6/2012 based on current available data; numbers are averages over the 5 year period.

| New Permanent Supportive Housing | 195 Chronically Homeless Adults per year |
Changing Strategies to Get to Zero Veterans

2011
- Shelter/TH only: 67%
- SH: 24%
- Prevention: 5%
- RR: 4%

2016
- Supportive Housing: 43%
- Affordable Housing: 19%
- Shelter/TH only: 13%
- Prevention: 15%
- RR: 10%
### Average Annual Housing Assistance Targets 2012-2016 Veterans

*Estimate as of 6/2012 based on current data; numbers are averages over the 5 year period. Overlaps with Chronic Homeless and Families tables.*

<table>
<thead>
<tr>
<th>Prevention Strategies</th>
<th>50 at-risk Veteran households per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Re-Housing</td>
<td>35 homeless Veteran households per year</td>
</tr>
<tr>
<td>Deeply Affordable Housing</td>
<td>65 homeless Veteran households per year</td>
</tr>
<tr>
<td>New Permanent Supportive Housing</td>
<td>45 homeless Veteran households per year</td>
</tr>
</tbody>
</table>
## Estimated Needs for Housing Assistance
### 2012-2016 (updated 6/29/12)

<table>
<thead>
<tr>
<th>Estimated needs for housing assistance, by type, among targeted households who will experience homelessness (unless prevented)</th>
<th>Families with Children</th>
<th>Chronically Homeless Adults without Children</th>
<th>Other Homeless Adults without Children (Veterans)</th>
<th>Unaccompanied Youth^</th>
<th>Total Targeted Households</th>
<th>Total Veterans^^ (included within columns to the left)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention Strategies*</td>
<td>520</td>
<td>0</td>
<td>240</td>
<td>TBD</td>
<td>760</td>
<td>250</td>
</tr>
<tr>
<td>Rapid Re-Housing*</td>
<td>920</td>
<td>0</td>
<td>160</td>
<td>TBD</td>
<td>1,080</td>
<td>170</td>
</tr>
<tr>
<td>Deeply Affordable Housing**</td>
<td>340</td>
<td>0</td>
<td>310</td>
<td>TBD</td>
<td>650</td>
<td>330</td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td>590</td>
<td>1,760</td>
<td>230</td>
<td>TBD</td>
<td>2,590</td>
<td>610</td>
</tr>
<tr>
<td>Estimated need that could be met through turnover of existing supportive housing units</td>
<td>(400)</td>
<td>(800)</td>
<td>(140)</td>
<td>(1,340)</td>
<td>(380)</td>
<td></td>
</tr>
<tr>
<td>Need for New Supportive Housing</td>
<td>190</td>
<td>970</td>
<td>90</td>
<td>TBD</td>
<td>1,250</td>
<td>230</td>
</tr>
<tr>
<td>Estimated Total Target Households Needing Housing Assistance 2012-2016</td>
<td>2,370</td>
<td>1,760</td>
<td>940</td>
<td>TBD</td>
<td>5,080</td>
<td>1,360</td>
</tr>
<tr>
<td>Estimated Persons in these households</td>
<td>6,780</td>
<td>1,760</td>
<td>940</td>
<td>TBD</td>
<td>9,490</td>
<td>1,480</td>
</tr>
</tbody>
</table>
Footnotes to Estimated Needs Table

* Does not assume permanent rent subsidies connected with prevention and rapid re-housing.

** Deeply affordable housing refers to subsidized rental housing that is affordable to persons living in deep poverty. Affordable housing and permanent supportive housing options can take the form of scattered subsidized apartments or the development of buildings through new construction or rehabilitation. The affordable housing numbers presented here do not include rent subsidies needed to prevent homelessness or that may be used in conjunction with rapid re-housing or permanent supportive housing. These numbers also do not encompass the need for affordable housing among low income households who are not experiencing homelessness. Significantly increasing the availability of rental housing that is affordable to households with the lowest incomes would be the most effective strategy for preventing and ending homelessness. The need for affordable housing in Connecticut is much larger than the number of affordable housing units needed to serve households who have become homeless.

^ The unaccompanied homeless youth population includes children and youth under 18 who are not residing with their legal guardians and young adults ages 18 through 21 who are not residing with families and who are experiencing poverty and homelessness. Obtaining accurate data on the prevalence and service needs of unaccompanied homeless youth is difficult. A Homeless Youth Study, in the planning stages, will conduct key-informant interviews with youth identified by community partners as “homeless, unaccompanied, and/or throw-away” and service providers currently working with this group. Using the qualitative information collected from the key informants, a quantitative measure will be constructed to “count” the challenges, resources, and needs of this group in an attempt to describe the experience of these young people and affect policy.

^^ 5% of homeless Veteran households are estimated to be families with children. 30% of homeless Veteran households are estimated to be chronically homeless adults. The number of permanent supportive housing units for Veterans assumes that 5% of these units would be for Veteran families; of the remainder, 60% would be for chronically homeless Veteran adults and 40% would be for other homeless Veteran adults without children needing supportive housing and not yet chronically homeless.
What’s happened since January?

WORKGROUP REPORTS
Opening Doors
Retooling the Crisis Response Workgroup

June 29, 2012
The Crisis Response Workgroup has two primary initial strategies:

- **Creating a comprehensive Rapid Re-housing Program** to serve literally homeless families and individuals.
- **Creating a coordinated/centralized intake system** for people who approach the homeless service system or who are living on the streets in order to divert people from entering shelter, quickly re-house people if they do need shelter, and hone program targeting for interventions such as prevention, rapid re-housing, and permanent supportive housing.
Retooling the Crisis Response Workgroup

Things we want to figure out?

• What additional funds will be needed in order to provide rapid re-housing services as an alternative to sheltering?
Retooling the Crisis Response

Things we want to figure out

• What is the relationship between localized coordinated/centralized intake systems and a statewide system?
  – Based upon our knowledge of how families and individuals access shelter a statewide frame for centralized intake for families make some sense if they fit into regional implementation strategies. But for singles, a very localized centralized intake process may be most appropriate
Retooling the Crisis Response
Things we want to figure out

• What would standards for rapid re-housing, for transitional housing, and for shelter include?
  – How would they be monitored?
Opening Doors
Affordable and Supportive Housing Workgroup

June 29, 2012
Affordable and Supportive Housing Workgroup

Main Objective: Strengthen our housing delivery system; create supportive and affordable housing at a scale sufficient to meet the need

Initial primary strategies:

- Embed strategies to end homelessness within State and municipal housing policies that prioritize and/or incentivize housing for people who are homeless; engage public housing authorities by building partnerships with service providers
- Build capacity in the housing development system
- Reduce barriers in the state funding process; specifically, identifying ways to reduce costs and time, barriers to leveraging other funds
Prioritizing or incentivizing housing for people who are homeless

Things we need to figure out?

• Identify opportunities in federal, state, and municipal housing programs that prioritize or incentivize housing to help eliminate homelessness, with particular focus on engaging public housing authorities to increase the number of units available to the homeless and at-risk populations, specifically looking at building partnerships with service providers.
Affordable and Supportive Housing Workgroup

Identify opportunities to build capacity in the housing development system

Things we need to figure out?

– Creating opportunities for development partnerships
– Providing funding, pre-development support, and technical assistance to build the pipeline
– Identifying and helping to form potential partnerships
– Identify system reforms to reduce costs and time, and increase leveraging of private and federal dollars
Affordable and Supportive Housing Workgroup

State Funding Process

Things we need to figure out?

• Identify the financing type and amounts needed build sufficient units to meet the needs identified

• Identify ways to reduce costs and time, the barriers to leveraging other funds, and what is required to reduce those barriers
Opening Doors
Economic Security Workgroup

June 29, 2012
Economic Security Workgroup
Strategy One

The workgroup has two initial areas of focus:

**Strengthen and sustain a statewide cross training initiative that can be implemented at the regional level** - professional development/technical assistance on the workforce and housing systems for individuals managing and providing direct services with the goal of supporting a culture that recognizes that people living in shelters and supportive housing can and need to work.
Economic Security Workgroup
Strategy One

• What do we need to know?
  – What is the goal?
  – What can we learn from other previous attempts at this or related goals?
  – To whom should the training / information sharing be targeted?
  – How can the training/information sharing be incorporated into on boarding efforts of workforce and housing organizations?
  – What incentives are required/can be created to encourage workforce and housing organizations to participate in this training / information sharing? To implement what they learn on an ongoing basis? To drive systemic change?
  – What are potential sources of funding for developing and implementing this effort?
Economic Security Workgroup
Strategy Two

**Regional Coordination** - convene regional groups to identify opportunities and barriers to utilization of workforce services, coordinate job development and program strategies, and provide support services, etc. to facilitate appropriate referrals, promote engagement in workforce programs and services and improve employment outcomes for individuals.

Coordinate with and integrate into TYP/CoCs planning process
Economic Security Workgroup
Strategy Two

• What do we need to know?
  – What attempts at coordination are currently underway throughout the state? Nationally?
  – What can we learn from those or related attempts? What is working? What is not working?
  – Who should be engaged in this effort? How can we best encourage key players to engage in this process?
  – What resources are necessary to support these regional groups? What can we do to make this sustainable?
Goals

Reduce medical vulnerability and frequent use of health care systems
• Align state and local strategies to support the goals of improved access to health care and effective integration and use of appropriate types of health services.
• Maximize the use of existing and new health sector resources to address both the housing and service needs of extremely vulnerable populations.
• Implement housing-based approaches to align with the health reform goals of prevention, greater access, better quality and lower cost.
• Expand use of HMIS to support new targeting approaches and to collect and disseminate quality data about use of healthcare systems.

Break the cycle of homelessness and re-incarceration
• Target housing resources and other supports to prevent and end homelessness among people leaving incarceration.
• Align housing resources and other supports to prevent and end homelessness among people leaving incarceration.
Opportunities

Learning, Evaluation and Model Development

• Pilot and track outcomes of health and housing integrated model through the Social Innovation Fund
• Outcomes and lessons learned related to FUSE Pilot
• Multi Year Supportive Housing Evaluation
• DSS Health Neighborhoods planning for Dual Population
• CNCS/CSH Medicaid Business Case Paper on Medicaid and Supportive Housing
• FQHC and LMHA Partnerships in 5 regions

Targeting Strategies

– Medicaid Data Match
– FUSE Data Match

Funding

• HHS Grant for Child Welfare Involved Youth
• Bringing FUSE to scale – 160 units in the 2012 budget
• Section 811 Application
Strategies

• Scan current and potential local partnering/coordination models
• Improve linkages with FQHC’s, clinics, hospitals, LMHA’s, drug treatment, etc
• Target frequent users of each system/multiple systems – inventory current targeting strategies; identify gaps; develop strategies to match data cross multiple systems
• Develop a formal Medicaid proposal with state partners to present to OPM
  – Develop Medicaid services package definition for supportive housing
  – Develop Patient Navigator role to bridge housing and health care
  – Define Workforce Development for integrated model
• Implementation of Medical Respite with connection to housing
• Define the role of housing and the housing system as well as housing outcomes for DSS for the Health Neighborhoods RFP development process
• Explore reinvestment of savings into housing
CT’s Roadmap to Financing Supportive Housing Services through Medicaid
The Opportunity

Limited funding to expand supportive housing

Health reform through ACA (Expanded Medicaid eligibility)

Search for non-traditional approaches to curb spending among high-cost Medicaid beneficiaries

Medicaid-financed supportive housing to improve health and housing stability and reduce costs among thousands of high-need, high-cost beneficiaries who experience homelessness

Supportive housing available virtually as an entitlement to homeless people with chronic health conditions
Outcomes

1. **More units** - Increase capacity/number if SH units in SH in CT

2. **More People** - Greater reach of SH to most vulnerable resulting in reduced costs related to overuse of high costs of crisis health services (ED, ambulance)

3. **Better Quality** - Greater integration with health care resulting in improved health access and outcomes for vulnerable individuals
Policy and Practice Considerations

• How do we show that supportive housing can benefit Medicaid (improve health while lowering cost among Medicaid high cost pops)?

• What SH services are Medicaid coverable and under which Medicaid authority can these services be covered?

• How do we build supportive housing provider capacity and infrastructure to use Medicaid (billing, training, etc)? and overcome fears of “medicalizing” supportive housing?

• How can we leverage and secure mainstream housing resources (rental subsidies, capital) and link them to Medicaid-financed care management in supportive housing?
• A significant portion of chronically homeless people with chronic health challenges are also Medicaid’s high-need, high-cost population

• Supportive housing has evidence of improving health and reducing Medicaid costs

• Supportive housing’s services match services that Medicaid benefits have covered

• CT has already dabbled in Medicaid for financing housing based services
SUPPORTIVE HOUSING POTENTIAL AS A MEDICAID SOLUTION
CT Preliminary Medicaid/HMIS Data Match

- Data set consisted of 8,132 clients
- 4,193 adults were matched.
- The top 10% or “high-cost utilizers” accrued ~$28.5 million in Medicaid service costs in 2011.
- The top 10% accrued more than 44% of the total spending of homeless population matched.
Average Annual Medicaid Payments per Enrollee by Cohort

- 10% High Utilizers: $67,987
- 20% High Utilizers: $47,796
- Aged: $22,074
- Disabled: $24,628
- Adults: $2,234
- Total: $7,437
Service Usage for Top 10% of Homeless High Cost Utilizers

- Acute Inpatient: 49%
- Drugs: 11%
- ED Visits: 10%
- SNF: 7%
- BH Outpatient: 5%
- Home Health: 4%
- OP Medical Services: 3%
- Med Transport: 3%
- State: 2%
- IP Behavioral Health: 2%
- Other: 2%
- Labs: 2%
- Dental: 1%
SH’s Impact on Use and Health Costs

- Reduction in emergency room use: 24% to 34%
  (Sadowski et. al., 2009; Perlman and Parvensky, 2006; Linkins et. al., 2008)

- Decreased inpatient admits/hospital days: 27% to 29%
  (Sadowski et. al., 2009; Linkins et. al., 2008)

- Reduction in detox utilization: 87%
  (Larimer et. al., 2009)

- Decrease in psychiatric inpatient admissions: 38%
  (Mondello et. al, 2007)

- Reduction in Medicaid costs: 41 to 67%
  (Massachusetts Housing and Shelter Alliance, 2011; Larimer et. al., 2009)
## Impact on Cost Per Beneficiary

<table>
<thead>
<tr>
<th></th>
<th>Top 10%</th>
<th>Top 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per person Medicaid costs for homeless, high-cost utilizers</td>
<td>$67,987</td>
<td>$47,796</td>
</tr>
<tr>
<td>Potential % Medicaid cost offsets from supportive housing</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Potential per person Medicaid cost reductions from supportive housing</td>
<td>$27,875</td>
<td>$19,596</td>
</tr>
<tr>
<td>Annual average per person cost of supportive housing</td>
<td>$19,500</td>
<td>$19,500</td>
</tr>
<tr>
<td>Potential annual per person savings</td>
<td>$8,374.67</td>
<td>$96.36</td>
</tr>
<tr>
<td><strong>Potential annual savings for 200 high utilizers</strong></td>
<td><strong>$1,674,934</strong></td>
<td><strong>$19,272</strong></td>
</tr>
</tbody>
</table>

% reductions needed to break-even with cost of supportive housing

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28.7%</td>
</tr>
</tbody>
</table>
SH’S COVERABLE SERVICES AND PAYMENT MECHANISMS
Most supportive housing services match Medicaid-eligible services. CSH “crosswalks” analyze what proportion might be coverable.

<table>
<thead>
<tr>
<th>Supportive Housing Services that Match…</th>
<th>Number of Services Categories (%)</th>
<th>Time in Service Hours Per Client Per Year (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Support Program</td>
<td>12 (26.1%)</td>
<td>157.75 (34.7%)</td>
</tr>
<tr>
<td>Recovery Assistant</td>
<td>13 (28.3%)</td>
<td>156.25 (34.4%)</td>
</tr>
<tr>
<td>Short-term Crisis Stabilization</td>
<td>3 (6.5%)</td>
<td>69.75 (15.3%)</td>
</tr>
<tr>
<td>Any Home and Community Based Service (HCBS)</td>
<td>28 (60.9%)</td>
<td>383.75 (85.4%)</td>
</tr>
</tbody>
</table>
The Future of Supportive Housing?

- Mainstream Housing Subsidies and Capital
- Grant-Funded Housing Stability Services
- Medicaid-Financed Care Management Connected to Health Care

The Integrated Health and Housing Model of the Future
## Comparison of Medicaid Authorities for Supportive Housing Services

<table>
<thead>
<tr>
<th></th>
<th>1115 Waiver</th>
<th>1915c HCBS Waiver</th>
<th>1915i HCBS amendment</th>
<th>Health Homes</th>
<th>Medicaid Rehab Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>Flexible waiver for demonstration programs that enable States to pilot innovative care delivery models and coverage expansion that differ from federal rules.</td>
<td>Medicaid waiver to provide Home and Community-Based Services to populations leaving or at-risk of institutionalization.</td>
<td>State plan option to extend Home and Community Based Services to people with disabilities but who are not at-risk of institutionalization without cost neutrality requirement.</td>
<td>CMS program that enables states to create highly integrated, coordinated, and flexible health and social services delivery networks for people with chronic conditions.</td>
<td>Authority traditionally used to cover range of recovery and rehabilitative services for people with serious mental illness and/or substance use disorders.</td>
</tr>
<tr>
<td><strong>Eligible/ Covered Populations</strong></td>
<td>Any Medicaid eligible. Can also be used to expand Medicaid coverage beyond federal eligibility (e.g. cover poor single adults prior to 2014).</td>
<td>Beneficiaries leaving or at-risk of institutionalization including elderly, people with mental illness, development disabled, PLWAs, or people with TBI.</td>
<td>Beneficiaries with disabilities requiring HCBS who meet approved “needs-based criteria”.</td>
<td>Beneficiaries with serious mental illness or two or more other chronic conditions.</td>
<td>No specific guidelines, but typically states use for beneficiaries with serious mental illness or development disabilities.</td>
</tr>
<tr>
<td><strong>Potential Coverage of SH Services</strong></td>
<td>High (gives States highest degree of flexibility).</td>
<td>Medium (due to cost neutrality requirement).</td>
<td>High (due to no cost neutrality standard).</td>
<td>High (service are highly tailored to members including intensive care management).</td>
<td>Medium to low.</td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
<td>States must meet high standards for research methods that will demonstrate better outcomes, lower costs.</td>
<td>Limited to people leaving or at-risk of entering institutions Subject to cost-neutrality.</td>
<td>States adopting 1915i must extend coverage statewide; cannot restrict targeting by geography.</td>
<td>A hybrid between a payment system and a care model, Health Homes is very new with only a few states adopted.</td>
<td>Services tend to be more treatment or rehabilitative as opposed to care management focused.</td>
</tr>
</tbody>
</table>
PROVIDER CAPACITY AND RELATIONSHIPS
Create New Provider Partnerships and Build Capacity/Workforce

- Providers will need to have processes for **credentialing, billing, developing services plans, systems for tracking and coordinating services**, and providing justifications for why these services are still needed.

- **Create process for training and credentialing supportive housing providers** to provide newly coverable Medicaid supportive housing services.

- Define service **workforce** titles, qualifications, and competencies as well as a career path.

- **Broker formal partnerships** between supportive housing and existing health providers that are already credentialed and experienced with Medicaid services delivery.

- **Health Homes** already entails **provider networks** where supportive housing providers can be part of a Health Home and linked to FQHCs, mental health services providers, hospital systems or other mainstream health entities.
Bud Clark Commons (Portland, OR)

- 130-unit PHA-owned and managed supportive housing
- Waiting list populated by referrals from 3 FQHCs using DESC Vulnerability Assessment Tool on clinic patients
- Services include:
  - PHA-provided housing stability services
  - 2 contracted mental health clinicians
  - Medical case management and primary and behavioral health services by 3 FQHCs
LEVERAGING HOUSING RESOURCES
Use New Services Models to Leverage Housing Resources

• Build collaboration between health, behavioral health and housing systems
  – Housing development/finance authorities
  – Public housing authorities

• Use new services opportunities created through Medicaid payment systems to leverage housing resources:
  – Rental subsidies like Section 8, Shelter Plus Care
  – Capital for “bricks and mortar” development

• Reinvest savings into housing
The Work Ahead...

- Define the target population
- Specify the SH services needing coverage
- Design the benefit and payment structure
- Identify the most appropriate Medicaid authority
- Make the business case to Medicaid
- Secure housing resources and design approach to link services with housing
- Develop provider partnership and build capacity and workforce
CT Integrated Health and Housing Neighborhoods

From Theory to Practice
Overview

• CIHHN is a
  – targeted
  – data driven
  – assertive outreach
  – care coordination model
  – utilizing local multidisciplinary teams to connect health care and housing

• Establishes local partnerships between FQHCs, LMHAs, supportive housing and shelter providers, and the state’s Medicaid Administrative Services organizations

• Improve health care experience and outcomes, reduce costs, create sustainability
A pilot to test the model is currently being funded by CSH Social Innovation Fund

Goals

• 160 new individuals who meet the target population definition will be placed in supportive housing within 18 months (starting April 2012)

• 85% of individuals placed into supportive housing will remain in housing 6 months following placement

• 100% placed in PSH who are Medicaid eligible and who remain in housing at the 6 month mark will be successfully enrolled in Medicaid at 9 months
Goals

• 100% placed in PSH and who remain in housing at the 6 month mark will be assertively engaged by a health professional around receiving health/behavioral health services

• 75% placed in PSH and who remain housed at 6 months will have had at least one primary care visit with a health care partner within 6 months following placement

• 50% placed in PSH who remain in housing at 6 month mark will have documented routine and regular visits with a health care partner for either primary care and/or treatment of a chronic condition within one year following placement
Capacity

Target numbers by geographic area:

• New London - 10
• New Haven - 40
• Hartford - 25
• Bridgeport/Stamford - 55
• Waterbury – 20
Teams

- Permanent Supportive Housing Provider(s)
- Local Mental Health Authority
- Federally Qualified Health Center
- Intensive Care Management (Medicaid ASOs)
- “Regional Coordinating Agency” operates and serves as the fiduciary
- Other community members may be invited to participate, as appropriate

Memorandum of Agreements (MOUs) will be signed to clarify roles and responsibilities
Data Match

• **Statewide Data Match** – Data from the state’s Homeless Information Management System (HMIS) is matched with CT Medicaid cost and claims data to identify a cohort of adults who are the most high cost utilizers of Medicaid services.

• ~ 400 people; 100 removed for control group, lists broken out by geographic areas
Data Match Implemented

- List of individuals flagged as meeting the “high cost utilizer” criteria are returned to the HMIS agency (CT Coalition to End Homelessness).
- **Release of Information** - CCEH creates lists for local teams that breakout whether the Release of Information (ROI) was signed or not
- Signed go to the Patient Navigator; not signed go back to the shelters
- Shelters work to get the ROI from client and then contact Patient Navigators (Patient Navigators check in regularly with shelters)
- There are ~12 shelters involved with project geographical areas
The Process

- Patient Navigator works with an experienced homeless outreach worker to conduct outreach and identify individuals on the list
- Assertive outreach - multiple attempts to engage clients and initiate intake (Streets, Soup Kitchens, Courts, Hospitals, ERs, Jails/Prison Staff, Ambulance)
- Once client agrees to participate, a project release is signed - team members can talk to one another and track their health costs/service utilization patterns
- An Intake will be completed by the Patient Navigator
- Housing placement is initiated immediately
The Process

• An Assessment is conducted by the Intensive Care Manager (ICM)
• A RAP Voucher application is completed and sent to D’Amelia and Associates
• Temporary Housing Strategies are employed by Supportive Housing Providers and the Team, including DMHAS Housing Assistance Fund (HAF)
• The client formulates a Wellness Plan with the ICM and Patient Navigator with input from the Team
• On-going Patient Navigation and Housing Stability services are provided
• Documentation, Documentation, Documentation
Final Outcomes

• Individuals are housed and connected to services
• The model is tested, refined and brought to scale